Request for Review by the Program Privacy Officer for Denial of Access to Health Information

Name	Date
Mailing Address	Medicaid ID# or Soc. Sec.#
City/State/Zip	

I Disagree with the decision to deny my request to access my protected health information because:
(You may use additional pages if needed)

_____ _____
Signature of Individual or Personal Representative Authorized by Law Date

_____ _____
Signature of Witness (If signed with an "X' or mark) Date

Return this form to: _____

_____

_____

DHH USE ONLY

Date received: _____ **Assigned to:** _____

Comments: (You may use additional pages if needed)

_____ _____
Signature & Title of Agency Representative Date

Sample Form: The Program / Office Mailing Address must be added.